# Third Quarter 2001 Summary of Incidents, Complaints, Enforcement Actions *

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**"Any complaints and or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051 (d). The text of these summaries will not appear in this report."**

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**SUMMARY OF INCIDENTS FOR THIRD QUARTER 2001**

I-7774 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7775 - Lost/Stolen Radioactive Material - Anheuser-Busch, Inc. - Houston, Texas

On July 26, 2001, the Licensee notified the Agency of the loss of three Generally Licensed self powered lighting signs containing approximately 4.5 to 5.5 curies of tritium each. The signs were removed from their normal locations while a contractor was troubleshooting a short circuit in the building where they were installed. After a weekend, the electrician returned to reinstall the signs and they were missing. An extensive search of the building and interviews with employees from the facility failed to locate the signs. No exposure to the radioactive material is thought to have occurred. The Licensee continues to search for the signs. The Agency will be notified if the signs are located.

File Inactive.

I-7776 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7777 - Dose Irregularity - University of Texas Southwestern Moncrief Cancer Center - Fort Worth, Texas

On June 29, 2001, the Registrant notified the Agency of a dose irregularity that occurred on June 26, 2001, when a patient was treated with the wrong energy beams during a therapy treatment. All calculations for the treatment were entered into an electronic medical record. The record was used to program parameters into the accelerator. During the copying process for AP and PA fields the energy was not changed for the PA field resulting in an 8.5 percent under exposure during the first treatment. The error was discovered during a routine physics check for the first treatment. To prevent a recurrence, all first treatments at the facility will be setup manually for each field. In addition, the Registrant's radiation therapists were reminded to check the chart prior to treatment and not to use the auto-setup function for first treatments. The referring physician was notified of the error and decided not to notify the patient due to current medical and psychological conditions. The treatment plan was revised to correct the initial under exposure.

File Closed.

I-7778 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7779 - Stolen Gauge - Terracon - Dallas, Texas

On July 16, 2001, the Licensee notified the Agency of the theft of a nuclear moisture/density gauge containing a 40 millicurie americium-241 source and a 10 millicurie cesium-137 source. The gauge was stolen from a company vehicle parked overnight at the home of the driver/operator. The chain securing the transport container to the truck was cut. The theft was reported to the Dallas Police Department. The Licensee offered a reward for the return of the gauge. The Licensee was cited for failing to maintain constant surveillance of the gauge. The gauge has not been recovered.

File Inactive.

I-7780 - Radioactive Material Lost & Recovered - Technical Welding Laboratories - Pasadena, Texas

On July 10, 2001, the Licensee notified the Agency that a radiography device containing 85 curies of iridium-192 was lost and recovered on that day. A radiography crew traveled to a temporary job site, exchanged radiography devices with another crew, then proceeded to another job site. Upon arrival at the second job site, the radiographers realized the radiography device was not in the truck. The radiographers searched the previous job site but did not find the device. One radiographer indicated the device was placed on the truck's back bumper and left unsecured. Within an hour, a county constable found the device at a street intersection. The constable placed the device in a patrol vehicle and arranged to meet the Licensee to return the device. The Licensee was cited for six violations of Agency regulations.

File Closed.

I-7781 - Radioactive Material Lost and Found - H & G Inspection Company, Inc. - Houston, Texas

On August 2, 2001, the Licensee reported the loss and recovery of a radiography exposure device on July 6 and 7, 2001. The radiography exposure device was secured in the back of a company vehicle for transport to a temporary job site. The radiographer assistant/driver did not arrive at the job site. The Licensee notified the Agency of the loss and established a search plan to locate the device and the driver. After a fruitless search along the route to the job site, the Licensee discovered the missing truck parked two blocks from the Licensee's headquarters. The exposure device was still secured in the vehicle. The driver's personal safety equipment was found in the front seat of the truck. Contact could not be established with the driver. The Licensee believes the driver quit without notifying the employer. No violations were cited.

File Closed.

I-7782 - Source Disconnect - Non-Destructive Inspection, Corporation - Clute, Texas

On August 1, 2001, the Licensee notified the Agency that a 37 curie iridium-192 radiography source could not be returned to the shielded position. An authorized consultant retrieved the source. The radiography device and accessories were sent to the manufacturer for evaluation. The manufacturer indicated a misconnect occurred because the connector was worn and no longer within operational specifications. According to the manufacturer if the control connector had been within specifications, the fail-safe feature would have prevented connection of the controls to the device if the drive cable was not first connected to the source assembly. The consultant received an exposure of 60 millirem during the retrieval. An Agency investigation determined the pocket dosimeters used during radiographic operations were not recharged at the beginning of each work shift. One radiographer's pocket dosimeter read off scale because it had not been recharged. The badge was sent for immediate processing and the reported whole body dose to the radiographer was 16 millirems. The Licensee was cited for failure to re-charge the direct reading pocket dosimeter as required.

File Closed.

I-7783 - Damaged Equipment - Diamond Shamrock Refining Company - Three Rivers, Texas

On July 9, 2001, the Licensee notified the Agency of a fire and explosion in their Alkylation Unit. Two nuclear gauges were located on the tower just above the explosion site. The gauges were surveyed and lockout/tagout was performed on the gauges. Both gauges had sustained shielding damage in the fire. An authorized recovery was performed on July 18, 2001. The gauges were surveyed on site, removed from the structure, packed for transportation, and transferred to an authorized disposal firm.

File Closed.

I-7784 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7785 - Medical Event - The University of Texas Medical Branch at Galveston - Galveston, Texas

On June 15, 2001, the Registrant notified the Agency of a medical event that occurred on May 23, 2001, when the patient was treated using the wrong treatment protocol. An Agency investigation determined that after treatment began, the therapist discovered the patient being treated was not the patient for whom the treatment protocol was prescribed. The therapist halted the treatment and reset the treatment to reflect the correct units prescribed for this patient. The therapist downloaded the computerized treatment protocol. The correct patient's name appeared on screen along with other patient's names. The therapist apparently clicked on the wrong patient's name and treatment protocol by mistake. Both patients had the same first name. To prevent a reccurrence of this mistake, the Registrant issued a detailed policy for daily treatment setups. The policy requires a series of checks to identify the patient, the prescribed treatment, the machine settings, and the recording of the actual units delivered to the patient. Two repeat violations were cited.

File Closed.

I-7786 - Radioactive Material Found - Shell Chemicals - Houston, Texas

On August 6, 2001, the Licensee notified the Agency that a 28 gram foil of uranium-238 was found on June 12, 2001 in a consignment package of items purchased at an auction. The Licensee determined the exotic metal wires surrounding the foil were dated in the 1950's. Since the radioactive materials license did not allow for possession of the uranium, the Licensee disposed of the foil on August 2, 2001 through an authorized broker.

File Closed.

I-7787 - Stolen X-Ray Equipment - Symphony Mobilex - El Paso, Texas

On August 20, 2001, the Agency was notified by the Registrant that a mobile x-ray machine was stolen from a company vehicle on June 25, 2001. The vehicle was parked at a local shopping mall. The theft was reported to the El Paso Police Department. An Agency investigation determined: the door lock on the vehicle was inoperative and could not be locked; the Registrant failed to immediately report the theft to the Agency; the Registrant failed to perform equipment performance evaluations on four x-ray machines; the Registrant allowed an uncredentialed operator to operate x-ray equipment; annual tests for defects in protective aprons and gloves were not performed, a repeat violation; operating and safety procedures were inadequate, a repeat violation; numerous required records were not maintained on the mobile van, a repeat violation; the Radiation Safety Officer failed to perform numerous required duties; and the Registrant failed to perform surveys of radiation levels in unrestricted areas to demonstrate compliance with applicable exposure limits. The Registrant was cited for the violations. The Registrant was referred for escalated enforcement actions.

File Closed.

I-7788 - Broken Brachytherapy Seed - UT Southwestern Medical Center - Dallas, Texas

On August 6, 2001, the Licensee notified the Agency that a sealed source was broken on June 15, 2001. While placing a needle containing radioactive seeds into a patient, the physician hit bone and bent the needle. The bent needle would not allow the seeds to be deposited into the patient. The needle with seeds was removed from the patient, placed in a shielded container, and stored for decay and removal of the seeds. The delay allowed sufficient decay for less exposure to the physicist handling the damaged needle. The bend in the needle caused one seed to break. This was not discovered until the seed was removed from the needle on July 30, 2001. A wipe test was performed and no contamination was detected on the exterior of the needle or the storage container. The contamination was confined to the broken seed and the interior of the needle. The seed was isolated and disposed.

File Closed

.I-7789 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7790 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7791 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7792 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7793 - Damaged Equipment - Washington Group International, Inc.- Houston, Texas

On August 23, 2001, the Licensee notified the Agency of damage to a radiographic device that occurred on July 26, 2001. The device, containing 43 curies of iridium-192, was damaged by a radiographer applying excessive force to the selector ring while attempting to connect the drive assembly. The device was placed in a transportation overpack and returned to storage. After disassembly, cleaning, and inspection, no visual signs of damage were noted. Upon reassembly, it was noted that there was play in the selector ring. A new storage cover was installed and the camera was returned to service. To prevent a recurrence: the radiographer involved was retrained on the equipment and informed to immediately notify the radiation safety officer of damaged equipment; both radiographers were reprimanded for failure to follow company Operating, Safety, and Emergency Procedures; all other exposure devices were inspected for wear or damage; this incident was discussed at the Licensee's biweekly safety meeting; and the old device cover was sent for evaluation.

File Closed.

I-7794 - Source Abandoned Downhole - Schlumberger - Houston, Texas

On August 22, 2001, the Licensee notified the Agency that on July 28, 2001, a 1.7 curie cesium-137 source and a 16 curie americium-214/beryllium source were abandoned down hole. A well logging tool containing the sources became stuck. Repeated attempts to retrieve the sources were unsuccessful. The sources were abandoned at a depth of 10,732 feet and 10, 714 feet, respectively. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7795 - * Health and Safety Code-Chapter 241.051(d)

File closed.

I-7796 - Radioactive Material Lost & Found - ATSER Corporation - Houston, Texas

On August 30, 2001, the City of Houston notified the Agency that a moisture/density gauge containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source was found on August 30, 2001. The gauge was found in a trash dumpster behind an apartment building. A local Hazmat team responded to the scene and requested Agency assistance to determine ownership of the gauge. The Licensee was identified and retrieved the source. The Licensee's technician indicated his personal vehicle was stolen along with the gauge. An Agency investigation found the following violations: the Licensee failed to immediately report a loss of radioactive material; a licensed source of radiation in unrestricted areas was not kept under constant surveillance or otherwise controlled to prevent unauthorized use or access; and the Licensee failed to return the gauge to the authorized storage location on August 29, 2001. The Licensee was cited for the violations.

File Closed.

I-7797 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7798 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7799 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7800 - Radioactive Material Lost - Texas Christian University - Fort Worth, Texas

On September 10, 2001, the Licensee notified the Agency that a 10 millicurie nickel-63 source could not be located. The source was housed in a gas chromatograph. The source had been stored within the instrument for over five years and was not used during that period. The instrument was discarded along with other instrumentation during May of 2001. The Licensee believes the instrument was sent to a sanitary landfill. To prevent a recurrence, the Licensee will provide an inservice for employees on proper disposal of radioactive materials, and will remove and properly dispose of radioactive sources from obsolete equipment. The Licensee was cited for improper transfer of radioactive material.

File Closed.

I- 7801 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7802- * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7803 - Badge Overexposure - Professional Service Industries, Inc., Houston, Texas

On September 12, 2001, the Licensee reported a 7,798 millirem exposure to a radiographer for the July 25, 2001 through August 24, 2001 monitoring period. An Agency investigation determined the radiographer lost his badge during radiographs that were performed at a pipeline field site. The radiographer found his badge on the ground during the second shot of the afternoon. He assumed he had lost the badge while carrying a 63 curie, iridium-192 camera to the second shot and did not report the loss to his radiation safety officer. Utilization logs and daily survey sheets for the monitoring period for the individual determined that the radiographer had not performed other radiographic operations. Calculations indicated that the maximum exposure during radiographic operations on the date of the lost badge could have been 7,230 millirem. His pocket dosimeter for the period indicated a total exposure of 130 millirem. This pocket dosimeter reading compared favorably with that of his radiography teammate. A deletion of the exposure was granted and a 140 millirem assessment, based on the radiographer's pocket dosimetry and his teammate's exposure, was accepted.

File Closed.

I-7804 - Lost Radioactive Material - Bemis Company, Inc./Arrow Industries - Terre Haute, Indiana/Dallas, Texas

On September 17, 2001, the United States Nuclear Regulatory Commission notified the Agency that a company purchased the assets of a Texas General Licensee and could not account for a gauge listed in the General Licensee's inventory. The film thickness gauge contained 150 millicuries of americium-241. An exhaustive search of the facility and interviews with previous employees of the defunct company did not locate the gauge. To prevent a recurrence, the purchasing company plans to stress to employees the importance of involvement of the radiation safety officer in the purchase, sale, and shipment of all equipment containing radioactive material.

File Inactive.

I-7805 - * Health and Safety Code-Chapter 241.051(d)

File Inactive.

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## COMPLAINT SUMMARY FOR THIRD QUARTER 2001

C-1573 - Regulation Violation - Robert S. Hamas, M.D. / Imaging Center Partnership dba Southwest Diagnostic Imaging Center - Dallas, Texas

On July 5, 2001, the Agency received a complaint alleging the Registrant allowed the performance of an aesthetic breast study by a mammography facility without the approval of an Institutional Review Board (IRB). An Agency investigation determined the study was not performed utilizing mammography equipment and was therefore subject to the facility's x-ray registration. The imaging, accomplished under a physician's order over a period of 1½ years and involved 52 subjects, was directed by a physician not employed by the Registrant. No violations were issued. Two physicians involved in the complaint were referred to the Texas State Board of Medical Examiners for possible actions under the rules of that Agency.

File Closed.

C-1574 - Regulation Violations - Sharp Radiation Services - Alvin, Texas

On June 28, 2001, the Agency received a complaint, forwarded from the State of Nevada, alleging a Texas Licensee falsified training documents during the year 2000. An Agency investigation determined the Licensee, authorized to conduct a radiography radiation safety course, signed Certificates of Completion although the Licensee did not conduct the 40 hour radiation safety course, during the time period from October 15, 2000 through October 18, 2000. The training was conducted by unauthorized individuals utilizing the Licensee's reference materials and test. The Licensee was cited for the violation.

File Closed.

C-1575 - Laser Burn - EuroSpa, Inc. dba European Skincare Institute / Rick K. Wilson, M.D. - Fort Worth / Plano, Texas

On July 9, 2001, the Agency received a complaint alleging a patient was burned by a laser on August 28, 2001. The complainant further alleged the treatment was not prescribed nor administered by a physician, but by a Registered Nurse. An Agency investigation determined the patient was burned by an Intense Pulsed Light device, not a laser. This device is not regulated by Agency rules. A physician involved with the facility was unaware of the treatment. When the physician discovered a Registered Nurse was performing treatments without his authorization, the device was removed from the office. The complaint concerned a device outside the regulatory authority of the Agency.

File Closed.

C-1576 - Laser Performance - A Better Way - No Needle Electrolysis dba GHR - No Needle Electrolysis - Dallas, Texas

On July 9, 2001, the Agency received a complaint alleging a laser device did not perform as advertised by the Registrant. The complaint alleged the Registrant advertised permanent hair removal and claims to have more hair now than prior to the treatments. The Registrant advertised permanent hair removal and permanent hair reduction. No before and after photos of treatment was available from the Registrant or the complainant. The complainant also alleged the operator was using an alias. It was determined the operator was using an alias, as alleged by the complainant, during the treatments. No records were available to demonstrate a physician authorized the treatment. An Agency investigation determined the facility had moved without notification to the Agency. The Registration was revoked before a notice of violation was issued.

File Closed.

C-1577 - Regulation Violations - Royce's Pharmacy /Jeff Phillips - Cleburne / Fort Worth, Texas

On July 11, 2001, the Agency received a complaint alleging a pharmacy was planning to conduct unauthorized bone density screening using an unregistered firm. An Agency investigation determined the firm was operating a bone density machine utilizing ultra sound to determine the bone density rather than x-rays. This machine is not regulated by the Agency and does not require authorization for use or screening from the Agency.

File Closed.

C-1578 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1579 - Therapy Event - Don and Sybil Harrington Cancer Center - Amarillo, Texas

On July 19, 2001, the Agency received a complaint alleging the Registrant treated a patient at the wrong treatment site during three therapy sessions. It was alleged that during the treatment the Registrant used the wrong markings for the treatment site and failed to use appropriate blocks for the treatment conducted. Concern was expressed for radiation doses to organs not intended to be treated. No report of the alleged therapy event had been received by the Agency. An Agency investigation determined the facility treated the wrong site due to failure to follow written procedures and hurried treatment to "work in" the patient. The therapist mistook the central ray tattoo for the superior marking while making port films. Port films were not reviewed before treatment was conducted. Treatments were repeated for three consecutive days utilizing the incorrect port films. The treatment resulted in an exposure to an area that would have been blocked under the prescribed treatment plan. Other organs were also unintentionally exposed. The Registrant failed to make the required 24 hour notification to the Agency and failed to make

the required written report within 15 days of the event. The Registrant was cited for the violations.

File Closed.

C-1580 - Regulation Violations - Plano Family Dentistry - Plano, Texas

On July 31, 2001, the Agency received a complaint alleging a Registrant allowed uncredentialed technologists to perform radiographs, the x-ray unit drifts and patients must hold the unit in place during radiographs, and oil leaks from the joints in the x-ray unit. An Agency investigation determined the x-ray unit was functioning properly and in compliance with Agency regulations. The allegation concerning the credentials of the technologists was referred to the Texas State Board of Dental Examiners for possible actions by the board.

File Closed.

C-1581 - Unregistered Equipment - North Texas Pain Associates (Firstcare) - Arlington, Texas

On July 31, 2001, The Agency received an anonymous complaint alleging an unregistered x-ray facility had been operating for more than 30 days. An Agency investigation determined the facility was unregistered and had been operating in excess of 30 days. In addition, the investigation determined: the facility had an uncredentialed operator for the x-ray equipment; the facility failed to monitor the occupation exposure of three persons working within the facility; the facility failed to conduct equipment performance evaluation of their x-ray equipment; and the facility failed to perform surveys of radiation levels in unrestricted areas of the facility to demonstrate compliance with the Agency dose limits. The facility was cited for the violations.

File Closed.

C-1582 - Uncredentialed Technologist - Urology Clinics of Texas - Dallas, Texas

On July 31, 2001, the Agency received a complaint alleging a Registrant allowed uncredentialed technologists to perform radiographs and that the items of non-compliance cited during the last inspection on January 4, 2001, were uncorrected. An Agency investigation determined an uncredentialed individual performed radiographs. Further, the Registrant failed to monitor the occupational radiation exposure to the individual. One violation from the previous inspection had not been corrected in that a radiation safety officer had not been appointed. The Registrant was cited for the violations.

File Closed.

C-1583 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1584 - Regulation Violations - River Oaks Imaging - Humble, Texas

On August 1, 2001, the Agency received an anonymous complaint alleging the Registrant charged unreasonable fees to provide mammogram films and the mammogram release form required the return of mammograms. Because the Agency does not regulate fees, the allegation concerning fees was referred to the United States Food and Drug Admininstration (FDA). The FDA considered the alleged fee reasonable and deemed no further actions necessary. An Agency investigation determined the authorization for release of films is a generic form used for all x-ray modalities at the facility and is not specific for mammography. Upon request, the facility does permanently transfer original mammogram films as required by regulations. The Registrant is considering revision of the form to specifically address mammogram films.

File Closed.

C-1585 - Regulation Violation - M & G Inspection & Testing, Inc. - Houston, Texas

On April 30, 2001, the Agency received a complaint alleging unsafe working conditions at temporary radiography job sites. The complainant alleged a radiographer was ordered by the Licensee to leave a radiography trainee unsupervised during radiography exposures on April 16, 2001. An Agency investigation determined daily radiation job sheets do not show the specified radiography trainee and the radiographer working together on the date alleged in the complaint. The radiography trainee indicated he was not unsupervised during any radiography operations. The allegation could not be substantiated.

File Closed.

C-1586 - Unregistered X-Ray Equipment - Commodity Control Services, Inc. - Pasadena, Texas

On June 4, 2001, the Agency received a complaint alleging a company was using an unregistered x-ray analyzer unit. An Agency investigation determined the x-ray analyzer was transferred to two other facilities but none had used the industrial unit. The unit was in a locked unused laboratory. The company was advised of the requirement to register if the unit is placed in use. An application for registration was provided to the company.

File Closed.

C-1587 - Unregistered X-Ray Service - U.S. X-Ray - Chesapeake, Ohio / Fort Worth- Houston, Texas

On August 17, 2001, the Agency received an anonymous complaint alleging an unregistered firm was performing mobile, screening x-ray procedures at a hotel in one city and had plans to do the same the following week at a hotel in another city. Agency inspectors determined the facility was not registered in the State of Texas and was performing mobile, screening radiographs, and unauthorized technologists performed the radiographs for three days in one city, even after an inspector had notified the facility that an Emergency Cease and Desist Order had been requested. The facility registered as a provider of equipment in the interim, however, the Cease and Desist order that prohibited the performance of radiographs was not rescinded. The Registrant was found operating in the second city in violation of the Cease and Desist Order. The Registrant was later found to be operating in a third city in violation of the Cease and Desist Order. The complaint was referred for escalated enforcement actions.

File Closed.

C-1588 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1589 - Regulation Violations - Network Cancer Care - Denton, Texas

On March 22, 2001, the Agency received an anonymous complaint alleging the Registrant had no full-time physicist working at the facility, the annual calibration of the accelerator was overdue, and the radiation safety officer had changed over thirty days ago without proper notification to this Agency. An Agency investigation determined: equipment spot checks were not made at proper intervals; both spot checks and calibration procedures were not in writing; the Registrant had not notified the Agency within thirty days of the change of the radiation safety officer; and the accelerator was left unattended with both the key and code in the machine providing the possibility of unauthorized use. The Registrant was cited for the violations.

File Closed.

C-1590 - Uncredentialed Technologist - Alamo City Imaging - San Antonio, Texas

On August 22, 2001, the Agency received a complaint alleging the Registrant allowed uncredentialed technologists to perform radiographs and the x-ray machine was on a slanted floor. An Agency investigation determined the technologists were credentialed as required and there were no structural problems found in the x-ray room that would be problematic to radiation safety or that would affect the production of x-rays.

File Closed.

C-1591 - Unregistered Equipment - Mobile Medical Services - Lubbock, Texas

On August 16, 2001, the Agency received a complaint alleging a mobile x-ray service had changed ownership and had failed to notify the Agency. A review of Agency records indicated the Registration had been terminated. An Agency investigation determined the facility was performing unregistered mobile x-ray services. The facility was cited for the violation.

File Closed.

C-1592 - Unregistered Equipment - Lance Ledoux - San Marcos, Texas

On August 23, 2001, the Agency received a complaint alleging an the use of an unregistered bone densitometry x-ray unit. An Agency investigation substantiated the allegation. The facility was cited for the following violations of Agency regulations: an application for registration was not submitted within 30 days of commencement of operation of a radiation machine; two individuals who operated the x-ray equipment were not credentialed as required; the registrant failed to monitor the occupational exposure to radiation of the two operators; and operating and safety procedures and records of receipt, transfer, and disposal records were not maintained at the location.

File Closed.

C-1593 - Unauthorized User of Radiopharmaceuticals - North Texas Cardiology - Sherman, Texas

On August 23, 2001, the Agency received an anonymous complaint alleging a doctor administers nuclear medicine in his office. The complainant also questioned the doctor's credentials to perform nuclear medicine. An Agency investigation determined that while the doctor is credentialed by the Texas State Board of Medical Examiners as a licensed practitioner, he is not Board Certified in Nuclear Medicine. He is the owner of the facility and does not perform nuclear medicine but specializes in cardiology and vascular surgery. The doctor denies he performs nuclear medicine and no evidence could be found to indicate the doctor has ever performed nuclear medicine. Three other physicians are employed by the facility as authorized users for diagnostic cardiology. The allegations were determined to be invalid.

File Closed.

C-1594 - Unregistered Laser - American Aesthetics, Inc. dba Pelage Spa - Flower Mound, Texas

On August 28, 2001, the Agency received a complaint alleging a spa was unregistered and operating without a licensed medical practitioner. A joint inspection by the Agency and the Texas Department of Health, Bureau of Food and Drug Safety determined the facility was registered and did have a physician associated with operations, but not always onsite during laser operations. The investigation also determined the facility had not registered within 30 days of placing their Class IV laser device into operation. The Licensee was cited for the violation. The complaint was forwarded to the Texas State Board of Medical Examiners for possible action under their rules.

File Closed.

C-1595 - Regulation Violations - Manchester Tank and Equipment - Lubbock, Texas

On July 19, 2001, the Agency received a complaint alleging radiographer trainees were required to work alone and without supervision. An Agency investigation determined the allegation was valid. Two radiographer trainees had performed radiography without supervision while the company's assigned radiographer trainer was on vacation. The Agency investigation also determined one trainee was not provided with personnel monitoring required by Agency regulation and the other trainee's pocket dosimetry readings were not recorded or kept from July 2000 until the date of the investigation. The Registrant was cited for the violations.

File Closed.

C-1596 - Regulation Violations - Ruiz Testing - San Antonio, Texas

On August 28, 2001, the Agency received a complaint alleging a Licensee used industrial radiography x-ray equipment unsafely; boundaries were not set up with signs and ropes; and survey meters were not calibrated. An Agency investigation did not substantiate the allegations.

File Closed.

C-1597 - Unregistered Laser - The Waterford Day Spa / Angelo Laser Center, Inc. - San Angelo, Texas

On August 24, 2001, the Agency received an anonymous complaint, referred from the Office of the Attorney General, alleging a facility was operating an unregistered laser without the supervision of a physician. Additional allegations were referred to the Bureau of Food and Drug Safety. An Agency investigation determined the facility was unregistered and although a physician was associated with the facility, he was not prescribing all laser treatments. All hair removal procedures were left to the judgement of either a registered nurse or one of four licensed estheticians employed by the facility as independent contractors. The facility was cited for the violations. The licensed practitioner and the registered nurse were referred to their respective professional licensure boards for possible actions under their regulations.

File Closed.

C-1598 - Regulation Violations - Apex Geoscience, Inc. - Tyler, Texas

On August 23, 2001, the Agency received a complaint, forwarded by the United States Nuclear Regulatory Commission, alleging : a nuclear gauge operator was not formally trained to use the gauge; other technicians may not have been trained; utilization logs were not maintained as required; personnel dosimetry was not provided; and the monitoring results were not provided to the employee after termination. An Agency investigation substantiated the allegations. The Licensee was cited for the violations.

File Closed.

C-1599

This complaint contains confidential personnel information. No summary will be written.

File Closed.

C-1600 - Regulation Violations - Conam - Pasadena, Texas

On September 10, 2001, the Agency received a complaint alleging: radiography devices containing sources were improperly controlled and left unsecured in the unlocked position; radiographers were overexposed, discarded their badges, and claimed the badges were lost; radiographers frequently do not wear the badges; survey meters are not always used; devices are not returned to storage after use but are taken home overnight; and the radiographers had a system for hiding lax security from Agency inspectors. An Agency investigation determined the allegations had already been investigated as a result of three previous complaints. There were no violations of Agency regulations found during this investigation that had not already been cited for the same time frame.

File Closed.

C-1601 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1602 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1603 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1604 - * Health and Safety Code-Chapter 241.051(d)
File Closed.

C-1605 - Regulation Violation - Alamo City Imaging - San Antonio, Texas

On August 31, 2001, the Agency received an anonymous complaint alleging the facility had failed to provide gonadal shielding for a child during an x-ray procedure. The complainant alleged the technologist indicated shielding was not required and the facility did not have small shields suitable for a child's pelvis. An Agency investigation determined it was impossible to isolate the particular procedure due to the anonymous complaint. However, the facility had available shielding and knew the required use during x-ray procedures. The complaint could not be substantiated.

File Closed.

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## INCIDENTS CLOSED SINCE SECOND QUARTER 2001

NO INCIDENTS WERE CLOSED SINCE SECOND QUARTER 2001

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## COMPLAINTS CLOSED SINCE SECOND QUARTER 2001

NO COMPLAINTS WERE CLOSED SINCE SECOND QUARTER 2001

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## APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE SECOND QUARTER 2001

NO HOSPITAL OVEREXPOSURES WERE REPORTED DURING QUARTER 2001

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## APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING THIRD QUARTER 2001

NO RADIOGRAPHY OVEREXPOSURES REPORTED DURING THIRD QUARTER 2001

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## APPENDIX C

ENFORCEMENT ACTIONS FOR SECOND QUARTER 2001

Enforcement Conference : G. H. Day Spas, Inc. - Houston, Texas - Laser

On July 10, 2001, an Enforcement Conference was held with G. H. Day Spas, Inc., dba Greenhouse Day Spa holder of Certificate of Laser Registration No. Z01408. The Greenhouse Day Spa representative attending the conference was Ms. Diane Black. Agency representatives attending the conference were Messrs. Quincy M. Wickson (Chairman) and Jim Ogden and Madames June Ayers, Cathy McGuire, Latischa Merrit and Shannon Edson.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of facility inspections conducted on January 29 and March 19, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. June Ayers reviewed the violations and the responses to the violations. After review of the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. A completed licensed physician form required by Division of Licensing, Registration, and Standards shall be completed and returned to the Agency within 30 days of the date of this Enforcement Conference. This was provided at the time of the Enforcement Conference.

2. A copy of the annual survey required under 25 TAC, Sect, 289.301(w)(1-5) along with a written procedure ensuring that the survey shall be completed on an annual basis should be submitted to the Agency within 30 days of the date of this Enforcement Conference.

3. The operating and safety procedures should include a statement: that if the physicians leave or their employment is terminated, no laser procedures will be performed until the physicians have been properly replaced.

4. An unannounced inspection will be performed within a year of the date of the conference.

5. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. The Registrant's representative agreed to these items and the conference was concluded.

Enforcement Conference: Texas Diagnostic Imaging Center - Amarillo, Texas - X-Ray

On July 13, 2001, an Enforcement Conference was held with Texas Diagnostic Imaging Center, holder of Certificate of Registration No. R23742. Texas Diagnostic Imaging Center representatives attending the conference were Messrs. Don Rogers and Chad Coffman, Director. Agency representatives attending the conference were Messrs.Quincy M. Wickson (Chairman), and Rick Munoz and Madames June Ayers and Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on April 27, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. June Ayers reviewed the violations and the responses to the violations. After review of the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The monthly checks currently being performed on the General Electric x-ray unit, Model No. 46-182298G2, Serial No. 44828WK2, will be continued until the unit has been disposed of and/or replaced. These monthly checks should include verification that the violations stated in the Notice of Violation issued by the Agency on May 3, 2001 remain corrected. All numerical readings should be recorded to verify corrective status.

2. The technique charts currently under development should be completed within 30 days of the date of this Enforcement Conference.

3. Unannounced inspections will be performed on a more frequent basis.

4. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Castle Dental Centers - Houston, Texas - Dental

On July 24, 2001, an Enforcement Conference was held with Castle Dental Centers, holder of Certificate of Registration No. R09023. The Castle Dental Centers representative attending the conference was Elouise Poutous, Project Manager. Agency representatives attending the conference were Messrs. Quincy M. Wickson (Chairman), Thomas Cardwell and Rick Munoz and Madames Jackie Carter and Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on January 13, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. Jackie Carter reviewed the violations and the responses to the violations. After review of the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. A corrected Notice of Violation will be issued elevating the severity level for violation number 2 of the Notice of Violation issued February 13, 2001 from a severity level IV to a severity level I. This is due to this violation being repeated as noted in several inspections conducted at Castle Dental Centers facilities.

2. The operating and safety procedures are to be revised to include correct regulatory references and names of individuals will be inserted instead of position references.

3. Administrative penalties will be issued due to the repetitive nature of the violation and compliance history.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Ground Technology, Inc. - Houston, Texas - Gauge

On July 31, 2001, an Enforcement Conference was held with Ground Technology, Inc., holder of License No.L05125. Ground Technology, Inc. representatives attending the conference were Dr. Asoke K. Deysarkar and Dr. Ruma A. Acharya. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman) and Arthur Tate and Madames Kitty Emerson and Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of facility investigations conducted on February 1, and February 7, 2001. These investigations determined that the number and severity level and repetitiveness of the violations noted during these inspections have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. Kitty Emerson reviewed the violations and the responses to the violations. The Licensee's representatives responded further to the Notice of Violation. After review of the violations and responses, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Licensee shall submit an amendment request to add all 35 users of radioactive material to their license. Along with the amendment request, the Licensee shall submit training records for all 35 users, and provide the information to the Agency within 30 days of the date of the Enforcement Conference.

2. During the course of the enforcement conference discussion, additional violations were uncovered specific to an unauthorized user and loss of control of the gauge. The Notice of Violation is attached to this summary. The response to the Notice of Violation should include corrective actions taken and actions taken to prevent recurrence of the violation.

3. The Licensee shall provide education/training, to include CPN training documents for Dr. Ruma A. Acharya and Shahriar Mahmood.

4. We will consider increasing the inspection frequency pending receipt of training certification documents for the RSO and the results of future inspection findings.

5. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Licensee's representatives returned and were informed of the items discussed during the caucus. The Licensee's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Dallas Southwest Medical Center, Dallas, Texas - Mammography

On September 6, 2001,an Enforcement Conference was held with Dallas Southwest Medical Center, holder of Certificate of Mammography No. M00113. Dallas Southwest Medical Center representatives attending the conference were Messrs. J. Cornelius Brown and Phil Middlebrook. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman), Thomas Cardwell and Jerry Cogburn and Ms. Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on June 7, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jerry Cogburn reviewed the violations and the responses to the violations. The Registrant's representatives further responded to the Notice of Violation. After review of the Notice of Violation and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested a letter verifying the number of mammography films read by Dr. Bradley, from the period of June 6, 1999 through June of 2000. The information shall be provided to the Agency within 30 days of the date of the Enforcement Conference.

2. The Registrant will provide the Agency with a copy of an adequate policy/procedure for the mammography medical outcomes audit program within 30 days of the date of the Enforcement Conference.

3. The Registrant shall provide the Agency with a letter from the Lead Interpreting Physician stating he will review the quality control program on a quarterly basis and provide documentation for Agency review at the next inspection.

4. Violation number three, on the Notice of Violation issued July 13, 2001, was rescinded.

5. The Agency has increased the inspection frequency for the Registrant.

6. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Atser Corporation - Houston, Texas - Gauge

On September 27, 2001, an Enforcement Conference was held with ATSER Corporation, holder of License No.L04741. The ATSER representative attending the conference was Mr. Johnny Tatum. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman), and Ruben Cortez and Madames. Helen Watkins, Kitty Emerson, Elizabeth Grimsley and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of facility inspection conducted on June 6, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. Kitty Emerson reviewed the violations, and the responses to the violations. The Licensee's representative responded to the Notice of Violation. After review of the violations and responses, the Licensee's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested the Licensee provide a current copy of their Operating and Safety Procedures, that would include a copy of their organizational chart listed by title, within 30 days of the date of Enforcement Conference.

2. The Licensee shall provide a written statement from Fred Martinez, President of the facility, giving the Vice President authorization to shutdown operations should the necessity arise. This authorization shall be added to the Radiation Safety Program.

3. An inventory shall be provided to the Agency within 60 days of the date of the Enforcement Conference. The Licensee shall conduct a monthly physical inventories until their next Agency inspection that will be available for inspector review at that time.

4. The Licensee shall provide leak test records to the Agency within 60 days from the date of the Enforcement Conference.

5. The Licensee will be placed on an increased inspection frequency.

6. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Licensee's representative returned and was informed of the items discussed during the caucus. The Licensee's representative agreed to these items and the conference was concluded.

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